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MEMORANDUM

TO: Legislative Oversight Committee
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional and Stakeholder Organizations

FROM: Allen Dobson, MD LAD mb

Mike Moseley

SUBJECT: Enhanced Services Implementation Update # 9
Billing for Medicaid Services for which Direct Enrollment with DMA is not yet Possible

There are a small number of Medicaid covered services for which providers cannot currently enroll to directly bill the Division of Medical Assistance. These include some services for which the endorsement "window" has not yet been concluded, such as detoxification services and High Risk Intervention – Residential (HRI-R) Level II Program Type and Level III facilities with less than four beds. Others include services which DMA does not plan to enroll because they will be phased out during SFY 2007, such as assessment and outpatient treatment services delivered by non-licensed or provisionally licensed staff. Finally, there are services for which we are awaiting approval from the Centers for Medicare and Medicaid Services (CMS) of a Medicaid State Plan Amendment (SPA) to permit direct enrollment, such as Therapeutic Foster Care (HRI-R Level I and Level II Family Type) and Targeted Case Management (TCM). In the meantime, until the endorsement process is completed or the services phase-out or CMS approves the SPAs, this small number of services can only be billed by Local Management Entities (LMEs). As providers become eligible to directly enroll to bill Medicaid services they must do so. Therefore, with the exception of the two services awaiting CMS approval, for which we cannot predict a timeframe, this situation will only exist through SFY 2007. For most of the services, the time period will be much shorter, ending no later than December 31, 2006.

In order to ensure the continued availability of these services to consumers during this interim period, we are directing LMEs to continue to process billings on behalf of providers for this limited numbers of services. We recognize that LMEs' System Management allocations for claims processing have been reduced since most providers of Medicaid covered services now bill DMA directly. The Department is prepared to

reimburse LMEs directly for providing this billing function. We are also removing any potential financial liability for Medicaid paybacks from the LMEs for performing these billing services for their providers. Until now, DMA held the billing provider responsible for any paybacks resulting from processing errors or audits of Medicaid services. Beginning July 1, 2006, DMA will hold the service provider – not the billing provider – responsible for such paybacks. This will remove any need for the LME to check medical records or treatment notes or to worry about whether the provider has received the appropriate prior authorization before processing bills. Any liability for these issues will be the responsibility of the service provider, not the LME.

Since we have removed the LMEs' financial liability for performing this billing function, we are requesting that LMEs process claims for all qualified providers in their catchment area for this small number of services. This includes all currently endorsed TCM providers and those TCM providers who may be endorsed in the future as well as all HRI-R Level II Program Type and Level III providers with less than four beds and Therapeutic Foster Care providers who have been previously accredited by a LME.

LMEs will process these claims using their existing 34-XXX provider numbers. The identifying number of the provider for which the claim is being processed must be listed in the "attending provider" field. Each month, DMH/DD/SAS will access a claims history file, determine the number of claims submitted by each LME for services rendered by other providers and process through a payment to the LME in the amount of 35¢ per claim. For this purpose, a claim is defined as a HIPAA 837 for at least one service for one consumer. The Division will pay the LME for processing the claim whether or not the claim is actually paid by DMA, since there may well be instances when claims don't process due to the failure of the provider to receive prior approval, etc. The Division will not reimburse LMEs for claims processed for services rendered by LME staff. Therefore, unless the "attending provider" field is completed to reflect a provider other than the LME, the claim will not count toward the claims payment amount.

Under this process, LMEs will be responsible for processing claims from providers in accordance with the existing "prompt pay" requirements, remitting to the providers the funds received for paid claims (note: LMEs are not required to pay providers in advance of the receipt of payment from Medicaid), and assisting providers, to the extent possible, to address issues with denied or pended claims. Providers will be responsible for submitting claims data in an electronic format to LMEs, ensuring they have met all Medicaid and DMH/DD/SAS requirements for service documentation and prior authorization, and making any payback of funds due back to the Medicaid program as a result of audits or other reviews.

We appreciate the cooperation of providers and LMEs to ensure that services to consumers are not negatively impacted during this transition phase for this very limited number of services. If you have any questions concerning this matter, please email contactdmh@ncmail.net.

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